IDAHO DEPARTMENT OF
HEALTH & WELFARE

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# Requests for Additional Services
# Early Periodic Screening, Diagnosis & Treatment (EPSDT)

If children (up to the age of 21) need medically necessary services (Personal Care Services) that exceed the Medicaid limitations, the state Medicaid program can approve the additional services through the Early Periodic Screening, Diagnosis & Treatment (EPSDT) benefit. When a child's primary care provider (PCP) determines during a well-child check-up that the child needs additional treatment for a health condition, the PCP orders the services for the child. If the services can't be provided by the PCP, the PCP will make a referral to an appropriate service provider.

Prior to obtaining the additional treatment/services, the parents/guardians **must** coordinate with the Personal Care Services (PCS) Agency for Medicaid authorization:

- Request for Additional Services – parent/guardian must complete this form
- Required documentation (by type of service requested) on the checklist form
- Service Provider Statement of Need – The agency supervising nurse must complete this form.
- Primary Care Provider Statement of Need – The child's PCP must complete this form.

After all of the required documents are submitted to Medicaid, staff who serve as subject matter experts for the types of services requested will review the information. In about two weeks, parents/guardians will receive a response from the department telling them whether the services were approved or denied.

# Request for Additional Services (EPSDT)

Instructions: The child's parent/guardian must fill out the front of this form and sign it. Service providers must give the parent the required documentation to accompany this request. Checklists of required documentation are on the back (page 2) of this form. The child's Healthy Connections Primary Care Provider (PCP) must also provide information on the Supplementary Statements form. All required documentation must be submitted before the Department of Health and Welfare can finalize the request.

Child's Name: _____

Date of Birth: _____ MID: _____

Parent/Guardian Name(s): _____

Address: _____ Phone: _____

_____

_____

I am requesting services in excess of the standard Medicaid benefit limitations:
(Please checkmark the services you are requesting and fill in the amount of each additional service)

| Service | Amount | Service | Amount |
|---|---|---|---|
| DDA Delivered Services:<br>☐ Developmental Therapy<br>☐ IBI<br>☐ Occupational Therapy<br>☐ Physical Therapy<br>☐ Psychotherapy<br>☐ Speech Therapy<br>☐ Supported Counseling | | ☐ Partial Care<br>☐ Personal Care Services (PCS) (Over 16 hours per week)<br>☐ PSR<br>☐ Psychotherapy (Mental Health Clinic)<br>☐ Service Coordination<br>☐ Other: | |

Signature Parent/Guardian: _____

Date: _____

For Department Use Only

Date Received: _____

☐ Approved
☐ Denied
☐ Incomplete

Reviewer: _____

Date Closed___: _____

# Required Documentation Checklist
# Request for Additional Services (EPSDT)

The department requires documentation to accompany each request for additional services that demonstrates:

- Why additional services are required.
- How the additional services will be used.
- That the additional services are medically necessary.

All requests for additional services **must** include the following documentation:

- □ A complete list of the type and amount of all services currently being received.
- □ A "Service Provider Statement of Need" from each provider of additional services requested (page 3 of this request).
- □ A completed "Primary Care Provider (PCP) Statement of Need" form (page 4 of this request).
- □ Current IEP/IFSP (if applicable).

Additional Required Documentation:

**DDA Services:**

- ☐ Individual Program Plan (current)
- ☐ Case Progress Notes (last 3 months)
- ☐ All Current Comprehensive Assessments
- ☐ Standardized Functional Assessment(s)
- ☐ Service/Treatment Plans for other services

**PSR & Partial Care Services:**

- ☐ Comprehensive Functional Assessment (current)
- ☐ CAFAS/PECFAS for past 30 day period
- ☐ Case Progress/ Therapy Notes (last 3 months)
- ☐ Psychiatric Diagnostic Evaluation (current)
- ☐ Service/Treatment Plans for other services
- ☐ List of Current Psychotropics
- ☐ Current Treatment Plan
- ☐ 120/240 day reviews (most current)

**PCS:**

- ☐ Plan of Care
- ☐ Current History & Physical (H&P)

**Psychotherapy (not in DDA):**

- ☐ Psychiatric Diagnostic Evaluation (current)
- ☐ Case Progress/ Therapy Notes (last 3 months)
- ☐ Current Treatment Plan
- ☐ 120/240 day reviews (most current)

# Supplementary Statements
# Request for Additional Services (EPSDT)

A statement from each provider of additional services is required.

## Service Provider Statement of Need

Provider Name: _____

Address: _____

Phone: _____

Describe what specific goal/objective can't be met without additional services:

_____

How long do you believe additional services will be needed to meet current goals/objectives: _____

_____

Date service eligibility established: _____
(only needed if eligibility for services is determined by the service provider)

Date of current treatment plan: _____
(if required to provide services requested)

I hereby declare that _____
(Name of Child and MID)

is eligible for the exhausted services and needs additional services. The additional services will be provided according to the current treatment plan. The services will not be provided for cosmetic purposes or for the convenience or comfort of the child, parent/guardian, or provider. There is no other equally effective course of treatment available or suitable for the child that is more conservative or substantially less costly.

Signature of Provider Representative: _____

Printed Name: _____

Title: _____

Date: _____

# Supplementary Statements
# Request for Additional Services (EPSDT)

## Primary Care Provider (PCP) Statement of Need

(If the child is enrolled in Healthy Connections (HC), the PCP providing this statement must be the HC PCP)

I am the primary care provider for _____
(Child's Name and MID)

□ I examined this child on _____
or
□ I reviewed the medical file of this child on _____

**Statement of Medical Necessity:** I agree that the additional services being requested are reasonably calculated to treat condition(s) of the child that endanger life, cause pain, or cause functionally significant deformity or malfunction. There is no other equally effective course of treatment available or suitable for the child that is more conservative or substantially less costly.

Signature of PCP: _____

Date: _____

Printed Name: _____

Address: _____

Phone: _____ HC Referral Number: _____

Date of last well-child check-up: _____

Approval of requests for additional services will only be granted temporarily if the child is not current in receiving recommended well-child check-ups.